NAME: James Michael Adams

DATE OF DEATH: Est. Death: October 29,1978
Pron. Dead: November 6, 1978

PLACE OF DEATH: Worcester County

SEE: 78-26875
October 1978
Worcester Co.

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

78 29507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year	2b. HOUR
SARAH	LORETTA	CAMPBELL	Nov. 22 78	12 NN

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
female	white	March 25, 1898	80 YRS					Nov. 22 1978	3P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Montana	USA		Worcester Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Pocomoke	1210 Market Street	retired saleslady	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Worcester	Pocomoke	YES ☒ NO ☐	1210 Market Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jacob		Layman	Sarah		Massie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		050-22-3527	Rev. James Wilkinson	By Pass Road Pocomoke, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCTION	FEW MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b)	HYPERTENSION	UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF (c)		

4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Dorothy C. Holzworth M.D.
EXAMINER'S NAME (Type) DOROTHY C. HOLZWORTH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county) SNOW HILL, MD.
22b. DATE SIGNED 11-25-78

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/25/78	First Baptist Cem.	Pocomoke Worcester Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Scott S. Melson	Pocomoke City, Md.	DEC 4 1978	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DHMH-17. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 78 29508

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MATTIE	MIDDLE: MURRAY	LAST: HAMBLIN	2a. DATE OF DEATH MONTH DAY YEAR: Nov 7, 1978	2b. HOUR: 5:40 P. M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JUNE 16, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD.	
10. CITY OR TOWN OF DEATH: WHALEYVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AT HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSE WIFE	12b. KIND OF BUSINESS OR INDUSTRY: —	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WORCESTER	WHALEYVILLE	YES ☐ NO ☒	R.D.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ISIAH	MURRAY		BELL	BREASORE	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
—	—	220-01-7976	HERBERT HAMBLIN OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
428X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Myocarditis
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 1968 to Date, 19 ____, that (I) (we) last saw the deceased alive on 11/1/78, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Clifford E. Jekett M.D.	☐ ☒ ☐	11/8/78

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Clifford E. Jekett M.D.	Berlin Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	11/11/78	EVERGREEN	BERLIN WORCESTER MD.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Peter Whaley Selbyville, Del.	NOV 13 1978	Whitney McCready

DHMH-16 60M 1/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 78 29509

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 7/77 (VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT) FIRST: GEORGE	MIDDLE: ARTHUR	LAST: JONES, JR.	2a. DATE OF DEATH MONTH DAY YEAR: November 6, 1978	2b. HOUR: 8:30 P M	
3. SEX: male	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 11, 1890	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.		
10. CITY OR TOWN OF DEATH: Pocomoke	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hartley Hall Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired farmer	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: rural	
14. FATHER'S NAME FIRST: George	MIDDLE: Arthur	LAST: Jones, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Sarah	MIDDLE	LAST: Payne
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: 217-36-0179	17. INFORMANT: Rumley Viola French Westover	ADDRESS: Star Route Pocomoke, Md. 21871	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4124 IMMEDIATE CAUSE (a) TERMINAL PNEUMONIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC DEBILITY

DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-30 19 69 to 11-6 19 78, that (I) (we) last saw the deceased alive on 11-6 19 78, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. G. Santiano DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 11-8-78

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. G. SANTIANO M.D.

22e. ADDRESS: POCOMOKE CITY Md. 21851

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11/9/78	23c. NAME OF CEMETERY OR CREMATORY: Remson Meth. Cem.	23d. LOCATION CITY OR TOWN: Pocomoke	COUNTY: Worcester STATE: Md.
24. FUNERAL DIRECTOR NAME: Scott S. Melson ADDRESS: Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR: NOV 13 1978	25b. REGISTRAR'S SIGNATURE: Virginia McCready	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

78 29510
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Gordon | MIDDLE: Wilkins | LAST: LaVaze

2a. DATE OF DEATH — MONTH: 11 | DAY: 28 | YEAR: 78

2b. HOUR: 9:45 M

3. SEX: M

4. RACE: W

5. DATE OF BIRTH — MONTH: 4 | DAY: 23 | YEAR: 1889

6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Belle Haven

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD

10. CITY OR TOWN OF DEATH: Snow Hill

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harrison House

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Va.

13b. COUNTY: Accomac

13c. CITY OR TOWN: Belle Haven

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS:

14. FATHER'S NAME — FIRST | MIDDLE | LAST:

15. MOTHER'S MAIDEN NAME — FIRST: Kate | MIDDLE: | LAST: Humphreys

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN):

16b. (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: Frances Daniels

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Renal Failure

5901

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Pyelonephritis

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. | MONTH | DAY | YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION — STREET | CITY OR TOWN | COUNTY | STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 8/12, 19 77, to 11/28, 19 78, that (I) (~~we~~) last saw the deceased alive on 11/24, 19 78, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Thomas L Jones MD

DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 11/28/78

22d. PHYSICIAN'S NAME (TYPE OR PRINT): THOMAS L. JONES, M.D.

22e. ADDRESS: 112 Pearl St., Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 1 1978

23c. NAME OF CEMETERY OR CREMATORY: Belle Haven Va

23d. LOCATION — CITY OR TOWN | COUNTY | STATE: Belle Haven Acc Co. Va

24. FUNERAL DIRECTOR — NAME | ADDRESS: Myrtle Jones Mapp, Belle Haven, Va

25a. DATE REC'D. BY REGISTRAR: DEC 5 1978

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

78 29511 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR AM
John	Earl	Whittemore	11/22		1978	10:20
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR AM
M	Wht	4 28 25	53 YRS.			11/22 1978	10:50

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Worcester MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Ocean City	2811 Plover Dr.	electrician	CONSTR.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS
Md.	Worcester	Ocean City		2811 Plover Dr.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Edwin		Whittemore	Marie	Brack	Whittemore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
yes WWII	219-16-8634A	Marjorie Whittemore-2811 Plover Dr.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

5193

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a) cerebral emboli

DUE TO, OR AS A CONSEQUENCE OF (b) corpulmonale

DUE TO, OR AS A CONSEQUENCE OF (c) chronic obstructive lung disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection X, Inquiry XX, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Thomas L. Jones M.D. TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED 11/22/78

EXAMINER'S NAME (TYPE OR PRINT) Thomas L. Jones, M.D. ADDRESS 2606 Phila. Ave., Ocean City 21842

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	11-24-78	DELMARVA CREMATORY	LEWES, SUSSEX, DEL.

24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ULRICH FUNERAL HOME	BERLIN, MD.	NOV 30 1978	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH-17
(VR A15 ME(5))
15M 7/76